Children's Reactions to Parental and Sibling Death

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A significant population of children will experience bereavement because of the death of a parent or a sibling. This grief is different from the bereavement seen in adults and needs to be understood in a developmental context. Cognitive and emotional understanding of death and dying in children gradually evolves with age. This report provides clinicians with information regarding the unique developmental elements in children that relate to the process of bereavement secondary to parental and sibling loss, risk factors for complicated grief, the warning signs of depression and anxiety beyond normal grief reaction, and the guidelines for intervention in children.

Introduction

Bereavement, grief, and mourning are terms that apply to the psychological reactions of those who experience a significant loss. Bereavement literally means the state of being deprived of someone by death and refers to being in the state of mourning. Grief is the subjective feeling precipitated by the death of a loved one. It has been used synonymously with mourning, although, in the strictest sense, mourning is the process by which grief is resolved. It is the societal expression of postbereavement behavior and practices [1].

At the beginning of the 20th century, approximately 25% of children in the United States had lost a parent to death by the age of 15 [2]. By the middle of the century, the decrease in mortality rates reduced this figure to approximately 10% [3]. In 1998, Ventura et al. [4] estimated that 4% of children would lose a parent by the age of 15 years. The next most commonly experienced bereavement in children is sibling death.

A child's reaction to his or her own impending death or that of others is related to the child's concept of death [5], which in turn is related to the child's developmental stage. Stages in a child's understanding of the concept of death have been well studied [6–10]. Four major concepts related to death have been described: irreversibility, finality, causality, and inevitability [6–9]. In a literature review, Speece and Brent [9] concluded that the age of acquisition of these concepts occurs between 5 and 7 years. They suggested that earlier studies reporting an older age of acquisition of the concept of death had significant methodologic flaws. If mourning requires a mature understanding of death and the psychic and cognitive acquisition of reality testing and object constancy, children are probably able to grieve but not mourn. In the first few years of life, children have virtually no concept of death except that the loved person has disappeared. When faced with death of a parent, however, children younger than 5 years of age may develop a precocious understanding of death. The role of personal exposure to death in development has been controversial. Several studies reported that such an experience may promote the acquisition of the concepts of death [11,12] but other studies have not supported this conclusion [13,14]. Cross-cultural comparisons [15–17] have found significant cultural variation but the underlying developmental framework was considered to be the same.

The concept of death continues to develop in children between ages 5 and 10 years. Difficulty in understanding death is clearly developmental, but some of the difficulty can be emotional. Children in this age group with a terminal illness have a marked awareness of the seriousness of their illness, even if never told that their illness is fatal [18]. Somewhere between 10 and 15 years of age, a child of average intelligence learns the meaning of mortality [19]. The child's reaction to death at this time is influenced more by his or her emotional struggles than by cognitive capacity.

Sibling loss in children younger than 5 years is compounded by the grief of bereaved parents. Young children may view the sibling's death as abandonment, punishment, the realization of unacceptable wishes, or as all three. Children between 5 and 10 are somewhat

more concerned for the dying child and may also be fearful for themselves. Although older children can appear overtly under emotional control, they may need special attention [20]. Children as well as adults may experience survivor guilt after the death of a child [21]. Some surviving children suffer serious symptoms and subsequent distortions of character structure [22]. Through identification with the deceased, surviving children also may manifest conversion symptoms and somatic symptoms [23]. In one report of conversion disorders in children, 58% were associated with unresolved grief reactions [24]

The literature regarding possible links between loss of a parent in childhood and subsequent psychopathology in adulthood is complex and limited by methodologic problems. Early reports, which were clinical in nature, presented vivid descriptions of the inner pain and confusion of young children secondary to parental death [25••,26,27]. The results of these studies, which supported generally held views as to the vulnerability of children to significantly stressful events, have been questioned because they are based on nonstandardized groups of children and did not use objective, standardized assessment measures [28–31].

Subsequent systematic investigations of children's short-term adjustment following the death of a parent, which used nonpatient samples and standardized assessment instruments, have yielded mixed results. Some studies reported that bereaved children who were mourning parental loss displayed considerable psychological pain. Furthermore, factors such as intense sadness, fear, aggression, depression, loss of developmental achievements, and academic problems interfered with development [28,29,32–36]. Others found that children who lost a parent to death appeared relatively symptom-free and were largely indistinguishable from nonbereaved peers [37–39]. In a recent study [40], Kalter et al. interviewed 40 children with parental loss and their surviving parent. They also obtained teacher reports. In general, these bereaved children appeared to be faring well. Some had heightened internalizing problems, however, and adolescent boys seemed to have the most difficulty. Surprisingly, group scores for the full sample of children were below national norms for nonbereaved children on depression and anxiety measures. The surviving parent's adjustment was the best predictor of the child's adjustment.

A child's response to the death of a sibling has been studied less than the response to the death of a parent. Studies to date suggest that loss of a sibling is potentially traumatic [41,42]. A child who loses a sibling must deal both with his or her own grief and with the family environment, which is likely to be altered as a result of the parents' grief. The surviving parents' ability to fulfill parental roles may be compromised [43]. The few published studies of sibling loss have suggested that children who lose a sibling are at no greater risk of emotional or behavioral problems than children who lose a parent. Most children who lose a sibling are well and may not need clinical attention, but some of these children may need help. Studies have suggested that younger children (preschool and school-aged children) and girls had more difficulties and manifested these difficulties with internalizing symptoms such as anxiety, depression, and withdrawn behavior, or with externalizing behaviors such as attention problems or aggression [42,43].

Evaluating a Child Who Has Lost a Parent or Sibling

Based on available data, a number of factors should be considered in evaluating a child who has lost a parent or sibling. These factors are discussed in this section.

Developmental level and understanding of death

A preschooler may perceive the death as merely an absence of the parent or the sibling, as they are not capable of understanding the irreversibility of death. Since preschoolers are in the stage of magical thinking, animism, and egocentricity, they may credit their own emotions of anger with causing the loss of the loved one. A 9- or 10-year-old is capable of expressing emotions by the use of puppets in play therapy; these children have the cognitive ability to accurately connect events and emotions.

Differences between the grief of a child and the grief of an adult

Although children can experience denial, guilt, sadness, anger, and longing for the lost loved one as adults do, there are distinct differences in the way the grief is expressed. Children have a limited ability to verbalize feelings of loss. They have a limited ability to tolerate the pain generated by the open recognition of losses. They avoid talking about it because they fear being "different" from their peers. Adults like to receive solace but children dread receiving it from anyone who is not immediate family. This fear is related to the normal developmental struggle of children and adolescents to gain control over their feelings. Thus they resist attempts to force them to express emotions. Children have a "short sadness span" [44]—that is, a low capacity to tolerate acute emotional pain for long periods. Grief is expressed on an intermittent basis over many years as an approach-avoidance cycle at their own pace. Children deal with grief in a displaced and disguised fashion in play therapy.

Cultural considerations

Besides these universal generalizations, cultural and religious experiences also have a mediating influence on the resolution of grief in children. Length of mourning and views about the public and private expression of grief differ widely and are influenced by societal, fam-

ily, and culture-specific criteria. Therapists must educate themselves about the specific needs and beliefs of a child before beginning therapy. Should children participate in the informal and formal rituals that surround the death? Most thanatologists believe that rituals are well suited to the developmental needs of children, who are fascinated by repetitive, prescribed, and structured experiences. Viewing the dead body, if the child so desires and is prepared ahead of time, allows for better resolution of the loss [45]. Viewing the burial in the cemetery may frighten very young children, so it may advisable to avoid that part of the perideath rituals [46••].

Differentiating normal from pathological grief

Timelines

In describing adult grief, Lindemann [47] acknowledged that grief has many manifestations. It can occur immediately, be exaggerated, or be completely absent. Denial or complete absence of grief is usually considered pathological in adults, however [48]. Because children try to avoid upsetting feelings and can tolerate discomfort only in small doses, quick resolution is unlikely and the lack of expressed grief should not be considered abnormal.

Intrusiveness

The degree to which a child can carry on usual daily activities and proceed with normal developmental tasks despite the grief determines outcome. If there is disabling interference in the social, emotional, and physical development of the child in the aftermath of the bereavement, professional intervention can be helpful. Symptom intensity rather than the symptoms themselves would be of concern. Grollman [49] suggested that continued denial of the reality of the death, prolonged bodily distress, panic attacks, extended guilt, increasing idealization of the dead parent or sibling, enduring apathy or anxiety, or unceasing hostility toward the parent or sibling are poor prognostic signs. Temporary emotional regression such as temper tantrums, aggression, dependency, loss of motor skills, or impaired learning should be considered normal, however.

Children can manifest displaced grief by heightened empathy for characters in a book or by appearing devastated over a seemingly trivial event. Children sometimes work through grief by taking on the mannerisms of the dead person, wearing his or her clothes, or becoming fixated on acquiring a belonging of the dead person. Children most at risk for pathologic grief are those with life-threatening illnesses, developmental delays, or preexisting emotional disturbances [50]. Intervention is needed when the child has suicidal hints, somatic problems, new difficulty with school work, nightmares, sleep problems, change in eating patterns, and frequent regression in behaviors [50]. The death of a parent or a sibling carries the highest-stress impact, followed by the death of a close relative [51].

Family assessment

Families have unique ways of handling grief. As a result, children's reactions are mediated by a variety of factors such as the nature of the loss and the surviving parent's response to the death, which may be dictated by their own experiences with death as children. At times, parents are so grief-stricken that they are unavailable to provide emotional support to their child. Extended family members can be a major support for the child in this situation.

Expression of emotions is a taboo in some families and acknowledgment of sad feelings may be discouraged. Conversely, some families successfully reassure the child of their importance in the family structure despite the loss and encourage the expression of sadness. Religion and faith-based concepts of death are protective factors for some families, who may portray the dead parent as a benign protector watching over the child.

Loss of a sibling leads to intense sadness in a child who also faces the altered behavior of parents who are grieving over the death of their child. It is essential to reassure the surviving child of their love, to reduce the burden of the loss. If the sibling bond was not loving, death can exaggerate the negative feelings and intensify survivor guilt. If families can reassure children that friction and negative feelings between siblings are normal, healing may be facilitated.

The child's history of coping with previous, everyday losses also helps to predict response to parental or sibling loss. Children with good ego strengths, those with prior exposure to death (even of a pet), and children with a good, effective coping style are deemed more resilient [46••,51].

Factors related to the death

The perception of the death within the family can be affected by whether or not the death was timely, anticipated (rather than sudden), stigmatizing (eg, associated with suicide, homicide, or a negatively viewed illness such as AIDS), painful, violent, traumatic, or preventable. This perception may mediate the response of the child to the loss. For example, the loss may not be acknowledged openly and then can result in "disenfranchised grief" [52]. This disenfranchised grief can lead to considerable internal anxiety that interferes with grief work. Thus, a child who has a difficult time comprehending the "voluntary" nature of a suicide may be given "half truths" to explain the death. As a result, the child has less than optimal support from family members, who are dealing with their own shock and grief. A mental health assessment is indicated in these special circumstances to ensure that grief work is progressing normally.

Factors related to premorbid functioning

Aside from developmental considerations such as the cognitive understanding of death in children, factors such as preexisting depression and developing depression must be evaluated [53••]. Preexisting depression puts a bereaved child at risk for complications such as

poor response to treatment in unsupportive or emotionally unavailable families. Every bereaved child should be evaluated for potential suicide risk, since children often perceive death as reversible and may try to "reunite" with the lost person. Fortunately, depression that develops secondary to a loss usually responds well to intervention.

Treatment Considerations

Death is generally viewed as inevitable and therefore falls within the realm of normal human experience. By inference, children should be able to successfully negotiate the loss of a parent or sibling with appropriate support from family and friends. However, even the most caring and compassionate surviving adults may be unable to provide adequate support to the child as they struggle with their own grief. To protect the child, many surviving spouses or parents do not talk to children about their grief. Children may not openly display their feelings, as they are afraid of losing control or appearing "different" from their peers. This façade suggests to the adults that the children are adjusting well to the loss. Often pastoral counselors or family friends assume the responsibility of helping the child or the family. Pastoral counselors are appropriate for uncomplicated grief. Referral to a mental health professional should occur in complicated grief, to ensure recognition of normal and abnormal regressions, dysfunctional reactions, and the interplay between psychodynamics and the environment on the grief process.

As already stated, warning signs that suggest the need for professional intervention are hints of suicidal thoughts, somatic problems, new difficulty with schoolwork, nightmares, sleep problems, change in eating patterns, and frequent regression in behaviors, if these signs are not abating.

A therapist should catalyze and support the grieving process and move at the child's pace, using play therapy to communicate symbolically. The referral should be made in a manner that does not make the child uncomfortable or pathologize the grief. Several therapeutic modalities can be included in the treatment plan of a child needing intervention:

Individual therapy

Individual therapy should broadly encompass three phases: 1) an early phase that focuses on developing some understanding but not allowing the child to become overwhelmed by the full impact of the loss; 2) a middle phase that allows the child to accept the loss and experience and bear the pain of the loss; 3) a final phase that focuses and consolidates the child's identity and aids the resumption of developmental progress [54].

Repetition of activities and statements in play therapy allows mastery of anxiety and provides safety to the child. Encouraging the recollection of pleasant memories of the dead parent or sibling is also effective in helping to resolve grief.

Family therapy

Family therapy should involve a thorough understanding of how the family views the loss and of the child's place in the grief process. The therapist is a neutral adult that the child can rely on when the rest of the family is working through their own grief. Walsh and McGoldrick [55] describe two tasks to be worked on with the family: acknowledgment of the loss and reorganization of the family system in view of the changed roles for all its members. In parental loss, a child may be thrust into a pseudomature parental role. This possibility must be acknowledged by the surviving parent and actively avoided so that normal development of the child can occur. Idealization of the dead person is common and should be examined for reality. In sibling death, comparison of the living child with the dead child should not be encouraged, as it can create feelings of unworthiness. Family members should be encouraged to express their feelings, as a model for the child of an appropriate and healthy response to loss. Acknowledgment of the loss by the entire family and the development of a specific common path to recovery can also be a powerful intervention.

Group therapy

When needed, group therapy should be based on the temperament of the child. Children who have suffered loss by suicide or homicide do not respond well to group therapy. It may be a good treatment for some children, however, as it reduces isolation. Groups that are open-ended may provide hope to the child as they work with members who are at different stages in their recovery.

Medications

Medications are indicated if the child develops symptoms of depression or if the child's functioning deteriorates significantly, leading to impairment in academic functioning or the development of suicidal thoughts. Selective serotonin reuptake inhibitors can be useful but must be monitored carefully for side effects and compliance with US Food and Drug Administration (FDA) regulations for their use in children.

Conclusions

Children experience loss in a qualitatively different manner than adults, based on unique developmental considerations. Furthermore, knowledge of differences in the expression of grief in children is necessary for intervention to be most effective. Distinguishing normal grief reactions from complicated grief requires a thorough assessment of individual, family, social, and cultural factors, including the unique relationship with the deceased parent or sibling. Further research is needed to more clearly define the grief process in children and to develop more effective interventions.

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